California Medicine
THE WESTERN JOURNAL OF MEDICINE

The Crisis Treatment of Suicide

NORMAN TABACHNICK, M.D., *Los Angeles*

■ *Almost all suicidal persons who consult physicians wish to live. Generally they fall into one of two groups. Interpersonal suiciders manifest frequent threats and attempts, are emotionally labile, have ill-defined suicide plans, and clear ideas as to how their crises might be resolved. Intrapersonal suiciders are less open in manifestations of suicidal drive, withdrawn rather than emotional, often have clearly-formulated suicide plans and do not have ideas (other than suicide) as to how their crises might end. The suicidal situation results from two factors: (1) the loss of some valuable person or commodity, and (2) the loss of self-esteem. What ensues is temporary character disorganization—crisis. Treatment is based on restoration or replacement of lost objects and building up of self-esteem.*

SUICIDE IS ONE of the most important crises with which practicing physicians must deal. There are a number of situations surrounding suicide which come to his attention. There is the case of the threatened suicide, the case of the suicide attempter who is seen (fortunately living) after a suicide attempt of greater or lesser severity has been made, and there is the situation of the family which has lost a member through suicide. These situations are crises not only for the victim and his family but for the physician also. There are perhaps few situations which can arouse so much anxiety in a human being as that of suicide or suicidal activity in someone with whom he is involved.

Some idea of the frequency of this situation can be obtained by a glance at the statistics regarding suicide. For the last few years, the number of completed suicides in the United States has varied between 20,000 and 25,000 annually.[1] The average rate for this country is 10 per 100,000 population. Less adequate statistics are available for suicide attempts, since no way has been devised of accurately recording all of them. However, estimates based on clinical experience and some suicide census studies indicate that for every completed suicide, there are at least eight suicide

This work supported by National Institute of Mental Health Grant #5-RO1-MH-14946.

The author is Associate Chief Psychiatrist, Suicide Prevention Center, and Associate Clinical Professor of Psychiatry, University of Southern California School of Medicine, Los Angeles.

Submitted, revised January 5, 1970.

Reprint requests to: Suicide Prevention Center, 2521 West Pico Boulevard, Los Angeles, Ca. 90006 (Dr. Tabachnick).

attempts. Probably the number of persons who talk about suicide and think about it would include the majority of the entire population. Thus, the suicidal continuum of thought and activity is quite possibly a universal phenomenon.

Studies at the Los Angeles Suicide Prevention Center indicate that approximately 70 percent of people who die by suicide have consulted a physician sometime within the last six months of their lives. Although it is possible that many of them have managed to conceal their suicidal intention, this figure represents an important challenge for the physician. This is true because it is well known that the suicidal person is most often ambivalent: He wishes to die, but he wishes to live. The engaging of the wish to live with appropriate action to accomplish this end is *the* task in the treatment of suicidal ideation.

In addition to the actual number of suicide events, there is another most important issue associated with suicide. This is the sorrow, grief and depression generated in the people involved with the suicide attempter.[2] A treatment of suicidal situations has as its aim not only the preservation of life but the alleviation of emotional turmoil in troubled groups of people.

The observations and suggestions in this article are based on the following sources:

- Approximately 45,000 suicidal patients treated at the Los Angeles Suicide Prevention Center in the past ten years.
- A review of the values and shortcomings of treatments of suicidal situations by non-psychiatric physicians, psychiatrists and psychologists in the Los Angeles area in the past ten years.
- A review of over 2,000 cases of death in which "suicide," "probable suicide," or "possible suicide" has been listed as "cause of death."*

The Two Important Clinical Groups

Suicide is not a rigidly defined disease entity but rather a type of reaction which people approach through different routes. However, review of the statistics of suicidal personality characteristics, both in living and dead suicide attempters, indicates that a valuable clinical differentiation can be made between the previously mentioned two main types of suicidal individuals, the interpersonal group and the intrapersonal group. As with all attempts to make broad generalizations about human beings, these classifications are not exact. The same variability of sign and symptom which can occur in any clinical syndrome holds true for suicide. It is also true that on infrequent occasions mixtures of these two types may be seen.

First, there are certain symptoms which are common to both groups. These include psychic depression, increased intake of alcoholic beverages and increased drug-taking.

The Interpersonal Group

In the interpersonal suicide group of suicide activities, the following characteristics are present:

- There are frequently suicidal threats, suicidal actions (attempts), and other intimations of suicidal behavior which occur in interpersonal settings. For example, an individual in this group might make frequent references to death, might declare to relatives or friends that someone who has recently died is "better out of it," or might communicate to others that he is considering various ways by which a person might dispose of himself in a quick and easy way.
- There are often emotional outbursts, quick flashes of temper, anger and anguish expressed toward others.
- There is frequently a history of previous suicidal behavior, ideation, threats or attempts.
- The suicidal plan which members of this group possess is usually not well defined. Often there is no plan apart from the intention that if things continue to go badly, some kind of suicidal activity will take place.
- "Interpersonal attempters" often have clear and definite ideas as to how their crisis might be easily ended. They sometimes may be initially reticent about discussing their ideas. However, once this difficulty is penetrated and a bond of trust has been established, the thought as to what might terminate the emotional crisis is easily forthcoming.

An example of the interpersonal type of suicide activity follows:

A 23-year-old married woman with two young children was seen at a hospital following the ingestion of approximately twenty 0.1 gram Nembutal® capsules which resulted in a fairly deep coma. About nine months earlier she had come to Los Angeles from Kentucky with her husband

*The cooperation of the Los Angeles County Coroner's Office under Drs. Curphey and Noguchi is gratefully acknowledged.

who was pursuing the possibility of a good job. They were relatively recently married, and neither had been away from their hometown before. The patient considered herself a somewhat introverted person and found it difficult to find new interests and friends in Los Angeles. Indeed, her own choice would have been never to leave her hometown, but she had deferred to her husband's wish.

In the time they had been in Los Angeles, she had become moody and irritable, subject to frequent outbursts of temper with regard to her husband and had become increasingly fond of alcoholic beverages and sleeping pills. She said that she was not sure what was causing her tension. However, when the interviewer pointed to her loneliness and isolation since the move, she quickly admitted that she felt these factors were very important in her present condition.

Although she had thought about suicide on a number of occasions and had possibly communicated some suicidal ideas to her husband, she had no clearly formulated suicidal plan. However, on the evening of the attempt, following a moody introspective session in which she could feel no hope for the future, she impulsively swallowed the 20 capsules.

The Intrapersonal Group

Specific symptoms in the intrapersonal group include:

- A progressive isolation from significant others and from valuable outside situations (such as job, church or club).
- The intrapersonal group differs decidedly from the interpersonal group in that the suicidal thoughts and activities are usually well concealed from others.
- Persons in this group tend to have well thought out suicidal plans and to have made preparations to implement them.
- They tend to be deeply depressed (as against the mild or moderate depression of the interpersonal group). They do not communicate their bad feelings, hopelessness and thoughts of suicide to others.
- They do not have available to them plans as to how their bad situation may be resolved (apart from suicide). One does not see quick "bounce-backs" from depression.

An example of this group is a 63-year-old single male. His close woman friend, after many weeks of urging, got him to go to the Suicide Prevention Center. At first he denied plans of suicide. However, he did indicate that he was increasingly depressed.

His difficulties seemed to have begun about ten years ago when his wife died. He took that loss very seriously and felt that he had never really recovered from it. Apparently during the depression that followed his wife's death his job performance decreased so that approximately two years after her death he lost the job that he had had for many years. He had drifted from one relatively non-skilled job to another, and usually each new job represented a step down. Recently, for long periods, he had been able to do no work at all and would spend a good deal of time in his cheap, one-room apartment, smoking and thinking.

He had had a woman friend for about a year, and at times they had been somewhat close. However, their relationship had recently begun to deteriorate. The friend did, however, think enough of him to try to get some help for him.

Only extremely active effort by a staff member induced him to continue his visits to the Suicide Prevention Center. Many times he would miss appointments, but usually after one or two calls he would come in again. He did manage to acknowledge that things were going very badly and that he thought of suicide and had a detailed suicide plan. However, it was very difficult for him to respond to the efforts of the staff member even though "all the stops were pulled out." After about two months of contact with the Center, he died in a fire that had apparently been caused when he fell asleep smoking a cigarette.

Treatment

Various aspects of the psychotherapy of the two types of suicide attempters will be discussed here, and it should be said at the outset that one important adjunct to treatment that will not be commented on in detail is the pharmacotherapy of suicide, although drug therapy is a tool that should be considered in many cases. Some principles which should govern the prescription of drugs are these: They should be given symptomatically to deal with depressive and agitated symptoms of the patient. When they are prescribed to deal with these symptoms and are not conceived

of as a definite treatment for the suicide-producing situation, they can be most helpful. However, it must be kept in mind that drugs alone will almost never take care of the underlying dynamic situation that is producing suicide. Precisely because they can alleviate symptoms, they can be a two-edged tool. The physician must also seek to identify, either through his own investigation or by referral to a psychotherapist, the specific suicide-producing factors in each case. Such factors, once identified, must be diligently pursued. Only when drugs are used in an ancillary manner with this approach do they have a rational place in the treatment of suicidal conditions.

There are a number of causative factors for different suicidal situations. However, it is possible to make a general classification of factors which tend to move a person into suicide. This classification consists of (1) an external trauma or loss, and (2) an internal loss of hope.

Externally, the trauma or loss can take many forms. The most frequent precipitating factor for suicide is the loss of a valuable person. This loss can take place in many ways. The most common include death, divorce and lovers' quarrels. In addition to the loss of a significant other person, there can be other traumas to the individual. For example, his self-esteem can be wounded because someone he thinks highly of depreciates him. Likewise, his self-esteem can be adversely affected by not receiving a promotion at work or advancement at school. Loss of health and loss of financial assets are also often seen as precipitating factors.

At the same time that an external loss occurs, suicidal people undergo an internal loss. This is the loss of optimism, the loss of their feeling that it is possible for them to confront difficult situations, to judge what might be of value in regard to these situations, and then to implement such decisions.

An example of loss of self-esteem is noted in the case of the 63-year-old man cited earlier. At the time of his wife's death, he had been functioning quite well. However, the depression which followed her death brought on many feelings of loneliness, lack of enthusiasm for his job, and a consequent failure in effective work. The heavy drinking which he then indulged in only added to a vicious circle of loss of self-esteem, decrease in effectiveness, further loss of self-esteem.

In rare cases, the physician will observe only one of these factors (external or internal) to be operative. However, in the overwhelming majority of suicidal situations both kinds of loss are demonstrated. Indeed, the physician feels he is observing a complementary phenomenon. People undergo external loss at many times in their lives. In most instances, although they may feel somewhat disheartened by their loss, they are quickly able to summon up their resources and go ahead to some other form of activity which they feel has meaning and value. However, a certain proportion respond to loss with feelings that "life is just not worthwhile anymore."

The loss of hope can take a number of forms. Sometimes suicidal persons feel that the particular loss they have incurred is one that is irreplaceable. Therefore, it makes no sense for them to try to get anything else and to go on living. At other times, the feeling is more focused on the *abilities* of the suicidal person. Although he considers it conceivable that some lost object might be restored or replaced, he just does not feel that *he* could accomplish this. From this standpoint, suicide seems an attractive solution.

Even though extreme hopelessness is present at this time, it is important to keep in mind that almost all suicidal persons are ambivalent, that is, no matter how hopeless and interested in death they may be, there is an accompanying wish for life. This knowledge can provide the spark for the physician's effort to reach out to the suicidal person.

An important accompaniment of the feeling of hopelessness is the crisis situation that develops. Perhaps because the suicidal person does not think he can succeed, he makes no effort directed to planning and judgment.

Very often the suicidal person shows a breakdown of his ability to put first things first. For example, a person who admits that he is close to suicide and indicates that he would like to live may yet demur at going into the hospital on the grounds that he has to take his cleaning to the laundry. When it is recommended that he take some medication to counteract his depression, he will raise serious objections that the medication may be so overstimulating that he will not be able to perform his job, or that it will make him drive poorly and dangerously or forget to eat. He will

act impulsively, perhaps deserting his small children in order to seek solace in drinking or solitary driving.

Finally, he will be prepared to commit suicide when he undergoes some slight frustration, not realizing that once he is dead he will have no opportunity to pursue pleasures and responsibilities which are still of importance to him.

The treatment of suicidal situations, then, must be aimed at the two categories of etiologic situations. If there is loss of hope and disintegration of the personality, then therapy should be aimed at reintegrating the personality and restoring hope. If there is a loss of external valued objects, then attempts must be made to restore or replace them. What are the specific methods of accomplishing these ends?

Reintegration of the Personality

An important keynote to the treatment of suicide is quick and decisive action. Most suicidal persons are in a state of turmoil which reflects their ambivalence about important issues in their lives. Should they stay with an unfaithful spouse, or should they leave? Can they afford to take a leave of absence from work or not? Indecision spreads from larger issues to smaller ones; for example, they may be plagued for hours by such trivial questions as what tie to wear.

In this situation, the quick recognition by the physician that a serious crisis exists and decisive action to implement improvement is of paramount value. Any point at which the physician senses that a suicidal crisis exists should become the starting point for quick action. He should request the patient to come in immediately and should be willing to make room in his schedule for dealing with this emergency.

Once the physician comes to a decision as to which actions will be therapeutic, he must act quickly to implement them. If he feels that a patient should go into a hospital, he must try to get the patient's consent immediately. Criteria for hospitalization include:

- A feeling of hopelessness that is not reversed during the initial interview with the patient. During this interview, the physician will have formulated a treatment plan. (For example, he may have decided that the patient should rejoin her parents, take an anti-depressant, and have regular psychotherapeutic interviews with him.) If the patient responds to the plan with a lifting of depression and a feeling that things may indeed get better, this is a positive sign. However, if there is no improvement following the communication of the therapeutic plan, this points toward hospitalization.
- The presence of a psychotic state.
- A history of repeated impulsive suicide attempts while in a depressed condition.

On occasion, a patient for whom admittance to hospital seems clearly indicated will refuse to cooperate with such a procedure. What course should then be followed by the physician? If the patient's condition is such that he clearly seems to threaten his own life outside of a hospital, then steps for commitment can be quickly taken. Either a family member or friend or the physician himself may initiate such commitment procedures by getting in touch with the nearest psychiatric hospital or general hospital that has psychiatric in-patient facilities.

There are, however, a number of cases in which the issues will be ambiguous. The patient may not be clearly psychotic. Although the physician may feel that suicide is a strong possibility, the patient may not be talking about suicide at the time. On occasion, some suicidal patients will deny that they have suicidal intentions, but it will be felt that they are lying. Under such conditions, if commitment may not seem possible the physician will often have to settle for less than the ideal. He must inform the patient of his grave concern, offer him whatever seems helpful that the patient will accept, and tell him: "I want you to know that I want to help you and I am available at all times. If you should change your mind about entering the hospital, please feel free to call me." Although there are a few patients who may kill themselves under such conditions, such a sincere and open declaration of interest in the patient will (1) often sustain him and help him through the crisis, and (2) sometimes be responded to by a request for hospitalization.

Sometimes the physician will feel that admittance to hospital is not indicated, particularly if the suicidal patient can be brought close to someone who is interested in him. Such a person may be a family member, a friend, a member of the clergy or a sensitive paid helper such as a nurse. With suicidal patients, it is often necessary not only to make such suggestions but to go a long way toward seeing them effected. Thus a physician

may make a call to a patient's relative, discuss the seriousness of the patient's condition with him, and request the relative to take the patient to his home. Not only may such action be lifesaving, it will help restore to the patient the feeling that he is important—important enough to make someone take time and make significant effort on his behalf.

Once having made a diagnosis of the suicidal crisis, a non-psychiatrist may wish to refer the patient to a specialist in psychiatry or psychology. In some cases, however, this will not be possible, and in others it may be quite feasible for a physician with sympathetic human feelings to begin treatment himself.

In any case, whoever undertakes the crisis treatment and psychotherapy of the suicidal patient will have to deal with loss of hope in a person who is not capable of making sound decisions. The task here is to point out to the patient that certain of his decisions are not in his own best interest, and to point out how new decisions might be better than the ones he has come to. For example, the individual who feels that it is more important to go to the laundry than to a hospital where his life might be saved could have this poor judgment pointed out to him. It could then be stated that his life is more important than his laundry, and the suggestion in favor of the hospital could be made again.

Activities such as these will not only help the patient toward life-saving and more rational decisions but will also provide him with valuable models of thinking. A patient observing a therapist who has about him an air of "putting first things first" can see that such rational thinking is preferable to his own impulse-ridden thoughts and actions.

An additional tool in the therapeutic armamentarium should be the holding out of hope on the part of the therapist. This need not be done by explicit references to the fact that hope is necessary. The attitude of hopefulness is much more importantly conveyed by the therapist's attitude that the situation does have a good chance of resolving in a hopeful manner. Also the therapist should know, and he may wish to convey to the patient, that crisis and suicidal situations are most often short-lived, that they are periods of turmoil which pass away with time and with therapeutic effort, and as they do pass away, the patient emerges with restored hope.

Consider the following example. A 52-year-old woman called a physician because of concern that she would act on her suicidal feelings. These had begun after the death of her mother. The two women had lived together for many years with no other close contacts. Although the patient was a quite capable woman who had not only taken care of the home but had supported the couple through her employment, she felt hopeless and incompetent at the time she called, and wondered whether life was worth living.

The physician listened to her story, sympathized, and then pointed out that depression and despondency at such a time were quite normal, and that adjusting to the loss of her mother and finding new important relationships probably would take some time and involve a number of difficulties. However, he also pointed to her assets as exemplified by her past successes and the competence which had been present up to the time of her mother's death. The physician gave her his honest opinion that she would almost certainly be able to achieve a new adaptation as time went on. In the interim, he assured her, he would see her at weekly intervals, would give her an anti-depressant agent if necessary, and would be available for her to phone at any time.

The patient was mildly encouraged during the first interview and showed it by a decrease in depression. Over the course of the next three months, she manifested gradual improvement and at that time was able to discontinue medication and weekly interviews. For some months afterward, she called the physician on the average of once a month and then these calls stopped. A follow-up call a year later found the patient doing well.

The question has been raised, "Does conveying to the patient that the crisis situation is relatively short-lived contradict the dictum that quick and decisive action is called for?" This contradiction is more apparent than real. The point is that a feeling that the crisis will *eventually* be overcome must not take the place of instituting definite plans to help *implement* its being overcome. As a matter of fact, if the latter is not accomplished during the period in which the crisis is present, there may be an unfortunate successful suicide attempt.

Restoration of Lost Objects

Next there is the issue of the restoration or replacement of the external objects. In the interpersonal group, this can often be fairly easily accomplished. Frequently a relationship which is deteriorating can be restored. A lovers' quarrel, an estrangement between two friends or relatives, can often be investigated for purposes of reconciliation, and often enough this possibility becomes an actuality.

In the case of the young wife whose history was described in earlier paragraphs, the following treatment ensued. When the husband learned of the cause for his wife's despair, he was overcome with guilt and was eager to do whatever would be possible to restore good and optimistic feelings in his wife. He readily agreed to return to their hometown, and a follow-up letter from the wife six months later revealed that things were going well.

Even in those situations where the specific lost individual cannot be restored, it is not too difficult to find substitute people or interests. Very often clergymen, business acquaintances or other friends of the suicidal, told of the patient's need for increased personal contact, will bring themselves closer to him. Sometimes they can be of great help by introducing the patient to new groups of people. We should not forget that many people welcome opportunity to be of help to others.

Nearly always the therapist willing to make the effort can find someone known to the patient who will agree to help in this friendly way. But if no one of that order can be found, it should be remembered that social workers, the Family Service, and the family groups of churches and certain social organizations are set up to help in such situations.

Also the possibility of the patient's reaching out for new interests and individuals should be actively explored. Attention should be paid to his own past history and his own personal predilection in the course of this attempt. Very often fraternal, school, church and social groups may be used in this endeavor.

In the intrapersonal group, the restoration of objects is much more difficult. This may be linked to the relatively less accessible approach to hope in these patients. However, by and large, the same means indicated to be useful in the interpersonal group should be attempted here.

One must expect, however, a much longer haul with intrapersonal suicidal patients. In this group, the therapist often becomes the new object. He must be prepared to enter into a long period of support and availability to his patient. He must recognize that although many patients will respond to this kind of therapy, the response may not be an easy or quick one. Such patients often become extremely onerous for internists, general practitioners or others who do not have the specific resources that trained psychotherapists have. However, should there be a feeling of particular interest or liking for such a patient on the part of a nonpsychiatrist physician, there would be no contraindication to his undertaking such a therapy.

Some may question that a person who is not psychiatrically trained could effectively treat a severely disturbed long-term patient. However, experience indicates that the qualification of genuinely caring for another person is perhaps the single most important condition in treating suicidal patients. Such a feeling of caring is probably more important in many cases than years of specialized training.

Certain suicidal situations demonstrate that the ministrations of a good friend can get someone through an extremely lethal suicidal situation. We have had an opportunity to utilize lay volunteers at the Suicide Prevention Center for many years. These people have come to the Center because of a feeling of wanting to help others, and they are accepted as workers when it is felt that they can effectively act on this motivation. This group has been consistently successful in dealing with suicidal situations, including many of the serious intrapersonal ones.

Of course, it is valuable to utilize the services of a consultant. Consultation is important even in the most highly skilled psychiatric treatment of a suicidal patient, and it is at least equally important in psychotherapy performed by persons who are not so highly trained.

In all suicidal situations, attention should be paid to the persons who are in one way or another near to or associated with the suicidal attempter. As already indicated, these significant others are often quite crucial in the treatment of suicide. In the first place they are important because it is often due to rifts or difficulties with them that the suicidal ideation is set into motion. Further, as already has been indicated, enlisting the support of the family

and those around the patient can often be of extreme help to him. It should be mentioned that the physician is not confining help to the suicidal victim when he is engaged in such collaborative work. Very frequently, the person who makes the suicide attempt is only the most obviously disturbed member of a group of people who are undergoing symbiotic problems. Often the suicide attempt of one member is the alerting signal by which an entire constellation of disturbed interpersonal relationships is brought to attention.

An example of the suicide attempter being the disturbed individual in a family group is the following:

A young man made a serious suicide attempt and because of it was admitted to hospital. At first he was reticent to talk about his condition but after some indication of interest on the part of the interviewer, the following story emerged.

He was in love with a girl whose background was unacceptable to his parents. Over the course of a year, the mother repeatedly told him that his marrying the girl would be extremely distasteful to her. Because of his great dependency on his family, this threw him into increasing turmoil which finally culminated in the suicide attempt.

In an ensuing interview with his mother, it became apparent that there was more to the matter than her dislike of the particular girl. Her own marriage was unsatisfactory to her, and she had only been able to maintain her sense of well-being by pouring all of her energy into the relationship with her son. The threat of his leaving her through marriage brought about increasing anxiety and thoughts of suicide. These concerns were important in her attitude toward her son.

It is obvious that in this situation, therapy had to be directed to mother and son, and eventually to the father also. (The latter was necessary in order to help bring together the mother and father so that the mother could relinquish the need for her son.)

The Family and Friends of Suicides

Next we will consider those unfortunate situations in which a suicide has actually taken place. Those surrounding the person who has killed himself will often feel responsible and guilty for the death. They must be reassured. They need the support of a philosophy of life which indicates that no person is omnipotent. They should be informed that, much though we may care for another person, there are forces that are greater than our own efforts which may act to make that person take his life. They must be reassured that their irritation and anger toward the dead person were not damnable sins but rather human reactions. Although it is natural that they should feel a sense of sorrow and loss, in most cases it is not appropriate for them to take the responsibility for the death upon their own shoulders.

Finally, a word should be said about the children of suicide victims, who not only have to live with the loss of one of the two most important people in their early lives, but also are left with the necessity to deal with the frustration and anger that may accompany such a loss. Although some persons might think that to feel angry toward someone who is so troubled as to kill himself is irrational (and perhaps it is), such feelings are also quite natural. A close watch should be made of surviving children so as to quickly identify indications of emotional turmoil. Such turmoil may manifest itself through any of the indications of psychological distress (anxiety, depression, psychosomatic symptoms, hypochondriasis, dissociative states, psychotic states). The point is that a suicide of a parent may often predispose a child to emotional turmoil in later life.

Author's note: A number of additional articles may be consulted by the clinician interested in treatment of suicidal conditions. These include: "Acutely Suicidal Patients" by Robert E. Litman, CALIFORNIA MEDICINE, 104: 168-174, March 1966; "Some Practical Procedures in the Management of Suicidal Persons" by Ronald S. Mintz, *American Journal of Orthopsychiatry,* 5:896-903, October 1966; and "The Suicidal Patient and the Physician" by Norman L. Farberow, Edwin S. Shneidman, and Robert E. Litman, *Mind,* 1:69-74, March 1963. An article which gives additional helpful material is "The Practical Management of Depression" by Nathan S. Kline, *JAMA,* 190:732-740, November 1964.

REFERENCES

1. Vital Statistics of the United States Department of Health, Education and Welfare, Washington 1964.

2. Tabachnick N: Interpersonal relations in suicide attempts. Arch Gen Psychiat 4:16-21, 1961